DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES

NOTICE OF ACTION ON REQUEST FOR STATE MATERNITY HOME FUNDS

Agency	County Number
Caseworker	Telephone Number -
Agency Address	E-Mail Address

Client Last Name	First Name	Middle Initial .	Birth Date	Social Security Number - -

☐ SMHF Application for maternity care has been approved. ☐ SMHF Application for maternity care has been reauthorized.

Date Received	Date Approved	Date Admitted	Due Date

Anticipated Care Days at $ Cost $	Provider	TANF Eligible?

Monthly Amount of Relative Contribution to Cost	$
Total Amount of Relative Contribution to Cost	$
Monthly Amount of SSI/TANF Contribution	$
Total Amount of SSI/TANF Contribution	$
Total SMHF Not to Exceed	$

☐ SMHF Application has been returned.

- ☐ Incomplete financial information
- ☐ Incomplete social information
- ☐ Missing signature(s)
- ☐ Other

☐ SMHF application has been withdrawn and case closed.
If future contacts with client suggest reconsideration of this case, please resubmit the application.

☐ SMHF application has been denied.

- ☐ Family financial resources seem adequate to meet cost of service
- ☐ Needs can be met without use of SMHF
- ☐ IV-E Eligible
- ☐ Other

If future contacts with client suggest reconsideration of this case, please resubmit the application.

Family Services Coordinator	Date	DSS Number

cc: Controller's Office
Provider
File
Family Services Coordinator

APPLICATION FOR STATE MATERNITY FUNDS
(VOUCHER, SOCIAL HISTORY & SERVICE PLAN)

PROBLEM PREGNANCY SERVICES

Today's Date: 9/12/2006

1. AGENCY INFORMATION

A. Agency	B. Caseworker
C. Address	D. Phone Number Extension E. E-Mail

2. APPLICANT INFORMATION

A. Applicant's Last Name	B. First	C. Middle Initial	D. Social Security # - -	E. US Citizen Yes

F. Birth Date	G. Race Other	H. # of Previous Pregnancies	I. Outcomes of Previous Pregnancies Live Birth Abortion Other

J. Marital Status Single	K. Highest Grade Completed	L. Current Living Arrangement Parent/Relative

M. Address	N. Expected Delivery Date
	O. Anticipated Admission Date

P. People Living in Household (Other than Applicant) Name Age Relationship to Applicant	Q. Applicant's Present Employer
	R. Applicant's Employer's Address

S. Sources of Income

Source	Monthly Gross Amount $

T. Monthly Resources Available for Placement Costs

Applicant $	Private Insurance $	Parents/Relatives $	Expectant Father $	Others $	Referring Agency $

U. Complete This Section if Applicant is Under the Age of 18

Parent's Last Name	First	Middle Initial	Social Security # - -	US Citizen Yes

Present Employer	Employer Address

V. For Office Use Only			
Family Size	Income Limit for This Size Family $	TANF Eligible? ☐	NCDSS Number

3. PROBLEM ASSESSMENT AND SERVICE PLAN

A. Is this a high-risk pregnancy? If so, explain.

B. What is the applicant's current plan for herself and her child after delivery?

C. Describe her family/friends/support system.

D. What efforts have been, or are being made, to help her receive needed services and support locally so that a residential placement might be avoided?

E. Why is this residential placement being considered?

F. Has she received SMF previously? If so, describe the placement including the residential setting, the year of entry, and the outcome for her and her child.

G. Service Plan for Applicant and Child

Service	Currently Provided (List Agency)	Planned For (List Agency)	Not Needed	Refused
Education				
Emotional Support/Counseling				
Employment and Training				
Family Planning				
Food Stamps				
Housing Following Delivery				
Income Assistance – TANF, IV-D, etc.				
Parenting Education				
WIC or other Nutritional Plan				
Other				

H. How will referring agency support this Service Plan?

4. RECOMMENDED RESIDENTIAL CARE PLAN

A. Proposed Living Arrangement

☐ Boarding Arrangement
☐ Licensed Family Foster Home
☐ Home of Non-Legally Responsible Relative
☐ Maternity Home: Name Alternative Life Programs

B. Explain how this placement is the least restrictive as well as the most cost efficient placement possible for this applicant.

C. Current Medical Care Provider

D. Alternative Living Arrangement (Complete this section if residential arrangement is other than a maternity home)

D.1. Is Form DSS 6189 (Rev. 11/03) attached?

D.2. Date of On-Site Visit	D.3. Name of Individual Maintaining Living Arrangement	D.4. Address

D.5. Describe Physical Environment (Sleeping Arrangement, Privacy, Space for Personal Belongings, Bathroom Facilities, Heating)

D.6. Describe Food and Nutrition Plan

D.7. Describe Laundry Facility

D.8. Describe Transportation Resources (Emergency Needs, Medical Needs, and Accessibility to Other Resources)

Describe Meeting Emotional Support
D.9.

Describe Addressing Special Needs
D.10

5. CERTIFICATION

I certify the information I have given is accurate and complete to the best of my knowledge. I understand that this information may be verified.

A. Applicant Signature	B. Date
C. Parent Signature (If Applicant is a Minor)	D. Date

E. Caseworker Signature	F. Date

Send original application to
State Maternity Fund Coordinator
NC Division of Social Services
P.O. Box 10063
Hickory, NC 28603

If additional information is needed, call (704) 462-2686

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

STATE MATERNITY FUND RESIDENTIAL CARE PROVIDER AGREEMENT

1. This Agreement is entered into between _____ (the agency providing problem pregnancy services, hereinafter the "Service Agency") and _____ (the residential care provider, hereinafter "Care Provider"), located at _____ for the provision of room and board under the provisions of the North Carolina Maternity Fund as set forth in Title 10A, Chapter 71L of the North Carolina Administrative Code and in accordance with the policies, procedures and standards in Volume VII, Chapter VI of the Division of Social Services Family Services Manual.

2. The Service Agency agrees to initiate contact with the State Maternity Fund to facilitate reimbursement to the Care Provider $_____ per day for room, board and the services described herein on behalf of _____ (hereinafter, the "Client"), commencing upon _____ (date Client to move to Care Provider's facility). Reimbursable expenses will cease to accrue as of the date the Client leaves the Care Provider or the date the pregnancy concludes, whichever occurs first. In any event, expenses will cease to accrue after 183 days.

3. The Care Provider shall collect no fee or other payment from the client for the services provided under this Agreement unless specifically authorized in Paragraph 10 below.

4. The Care Provider agrees to furnish appropriate sleeping accommodations, at least three nutritionally balanced meals per day, linens, laundry and utilities for the Client from _____ (date Client to move to Care Provider's facility) until either the date the Client leaves the Care Provider or no more than 14 days after her pregnancy is concluded, whichever occurs first.

5. The Care Provider further agrees to immediately notify the Service Agency of any of the following, and to obtain any necessary waivers or releases from the Client in advance so as to be able to provide such notice:

a.) when the Client leaves the Care Provider;

b.) of any conditions of which the Care Provider is or becomes aware that might negatively effect the Client's pregnancy or the completion of this agreement; and/or

c.) of any medical emergency involving the Client by telephone calling as follows: (i) Monday through Friday, _____ a.m. to _____ p.m., _____(individual or program to be called) at _____ (telephone number, including area code); (ii) at other times, _____ (individual or program to be called) at _____ (telephone number, including area code).

6. The Service Agency agrees to keep the Care Provider informed of anticipated or actual changes in the service plan for the Client that might affect the terms of this Agreement and will consult with the Care Provider as needed.

7. The Care Provider is not responsible for medical care and/or social services for the Client. The Service Agency will provide, make arrangements for, or otherwise attend to medical care and social services for the Client.

8. The Care Provider is aware of G.S. § 131D-1 governing maternity home licenses, and avers either that the Care Provider is currently holds such a license or is not required to have such a license under the terms of the law.

9. The Care Provider is aware of G.S. § 48-10-101 and § 48-10-102 governing prohibited activities and unlawful payments relating to adoption, and agrees to obey these laws.

10. This Agreement also includes the following (If not applicable, so indicate):

11. This Agreement may be terminated by either party upon five days notice, or immediately upon mutual consent.

Service Agency	Care Provider
Signature _____	Signature _____
Title _____	Title _____
Date _____	Social Security # _____
	Date _____

Service Agency Contact _____

Address _____

Telephone _____